United Ambulance Service
Serving Central and Southern Maine

CAAS ACCREDITED

Home Visit Program
Referral Form

Date: _____

Referred by: _____ **Phone:** _____
(Printed Name & Title)

Fax: _____

PCP Office: _____

Address: _____

City/State/Zip: _____

Client Information:

Name: _____ **DOB:** _____

Address: _____

City/State/Zip: _____

Phone: _____ **E-mail:** _____

PCP Referral Authorization:

PCP Signature: _____ **Date:** _____

☐ **Program was discussed with patient** ☐ **Patient records faxed**

(over)

Reason for Referral:

Past Medical History:

Past Surgical History:

Services Requested:

(Please check all that apply)

☐	**Available Resources and Series Consultation**	☐	**Medication Compliance & Reconciliation**
☐	**Home Visit & Safety Check**	☐	**Well-being visits (Bi-Weekly/Monthly)**
☐	**Activities of Daily Living Assessment**	☐	**Vital Sign Check**

☐	**Blood Draw**	☐	**Point of Care Testing / CLIA Waived Testing**
☐	**Chronic Disease Education**	☐	**Wound Check / Care**

Any additional/ background information:
(Living situation/ Challenges/ Disabilities)

**** Please fax this completed form to:**

207.777.6010

If questions, contact:
United Ambulance Service
Prevention & Wellness Program
192 Russell St.
Lewiston, Me. 04240
207.440.2662
prevention@unitedambulance.net

Office Use:

Date Received: _____ Initial Appointment Date/Time:_____ /_____

Prevention & Wellness Coordinator: _____
(Printed Named)

##END##